Stretched to the Limit by COVID-19, Will Providers Get Relief from Medicare Value-Based Programs?

written by Theresa Hush | April 16, 2020



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COVID-19 continues its inexorable, exponential spread here in the U.S. Hospitals in New York City, now accounting for more than 7 percent of confirmed cases worldwide, have less than a quarter of the critical equipment and supplies needed to serve an overwhelming surge of patients. Our health care providers are facing impossible choices, even considering universal Do Not Resuscitate orders for patients with COVID-19.

Less than one month ago, CMS was closing applications from providers willing to be part of a major movement to adopt financial risk as a new type of payment model. Under Direct Contracting, providers would face per-patient spending limits under a capitated payment scheme. Now that movement could be in question, along with other provider Risk programs, as total and

per-case spending soar under COVID-19.

With the public health crisis upending life everywhere and provider capacity already stretched to the limit, will Medicare continue its full court press for providers to adopt financial risk? Conversely, how will CMS loosen efforts to control health care costs when its own expenses for the highest risk group of coronavirus patients will overrun the federal budget?

> Already, those costs are estimated to increase exponentially.
> The National Association of Accountable Care Organizations (NAACOS) estimated that Medicare would be hit by COVID-19 claim costs of between $38.5 billion and $115.4 billion in the next year, depending on pandemic expansion and hospitalization rates.
> In addition, the $2 trillion stimulus plan—not likely to be the last—will expand the already mushrooming federal deficit.

One thing is certain: No matter what the trajectory of the outbreak, it will result in future budget cutbacks on spending. The only question is when those will begin. Let's look at some of the possible scenarios ahead for providers, consumers, and Medicare.

Scenario 1: Medicare will implement Risk Payment Models for providers, including Direct Contracting and ACOs, as planned.

Depending on economic pressure, CMS could stay on the current risk track with its Value-Based Health Care programs. NextGen

ACOs could be allowed to expire, and Direct Contracting could proceed toward a performance year and its capitated payment mechanisms. Shared Savings ACOs could remain on the "glide path" scripted by current regulations, and be under risk.

The problem is that this effort could induce some ACOs to leave the program, if there are no concessions on COVID-19. Depending on which provider ACOs exit, their departure may be important enough for CMS to be more lenient. It's too early to tell how CMS will view its options, especially as it has been less forgiving with ACOs than with direct providers, especially physicians, or with Medicare Advantage plans.

Scenario 2: Risk Payment Models will continue, but adjust Risk to carve out COVID-19 costs.

Medicare could continue to roll out payment models that drive providers to adopt risk, but create carve-outs for costs associated with COVID-19, especially for hospitalized patients. While this scenario addresses vulnerability for providers, it does not recognize the rising health care costs borne by consumers through premiums, copayments, and other provisions. Millions of Americans have struggled to meet high deductibles and copays under the best of circumstances, and with months of lowered or no income during this period, many will hardly be able to afford higher insurance costs going forward.

Nor, if the emergency magnifies into a long-term recession, will many companies be able or willing to pick up a bigger share of coverage costs. Medicare has ensured first dollar testing coverage, but consumers will still face a much

different “risk” environment for their own budgets because of higher medical costs, the problem of “out of network” coverage when COVID-19 care cannot be provided in all settings, and the threat of frequent viral re-emergence.

If there is a longer term recession, it may not be possible for CMS to address provider cost concerns without also dealing with the impact on consumers. That makes this a much more costly scenario—and more unlikely.

Scenario 3: Providers will remain in Implementation Year stages, with CMS delaying the start of Performance Year payment models.

Some hospitals—even some regional health systems—could collapse under the surge of severe COVID-19 cases. The spending ability of hospitals and local health systems is not infinite, nor is their expansion capability. Despite the overwhelming numbers right now, we are at an early stage in the surge. Whether there will even be enough hospital beds to handle the volume of patients, an urgent question now in New York City, is a question that is likely to be repeated throughout many areas of the country. The fact is that we don’t know whether we can prevent local hospitals and health systems from collapsing.

CMS will, no doubt, have to reckon with the prospect of adding financial risk to an already-overextended health system. Delay in the actual instruments of risk, like capitated payments or paybacks of over-expenditures, could be allowed. But because of its own budgetary pressures, CMS may not want dismantle reforms too easily.

There could also be negotiated solutions, such as longer-term payback or more reinsurance of risk, to assuage providers, while CMS keeps mostly on track with payment models.

Of course, given that the COVID-19 outbreak is still surging upward, it may be that Scenarios 2 and 3 could be consolidated into a complex carve-out/temporary push back solution.

Scenario 4: CMS will expand and encourage Medicare Advantage while scaling back regulations for provider Risk programs.

It is also conceivable that CMS will look to further privatize Medicare through Medicare Advantage plans and create a buffer for the direct costs that will hit the traditional Medicare budget. This scenario would be in keeping with CMS's favorable view of Medicare Advantage as well as the commitment to working through the private sector in other federal programs– like current efforts to increase the supply of personal protective equipment via private manufacturers.

Surviving the Pandemic Will Be a Long-term Effort that Extends to Post-Pandemic Surveillance

COVID-19 will be with us well beyond the next few months. Until there is an effective vaccine and proven treatments to lessen the virus's severity, vulnerable individuals will remain vulnerable. As routine care is severely reduced to free up resources for the sickest among us, those with chronic conditions who do not receive regular check-ups will get sicker, as well. There is already evidence of virus after-effects on liver function and cardiovascular disease in some

patients. In other words, the pandemic will not end entirely, but create a new set of criteria that health care providers must be ready to address.

How the health care system will weather the existing crisis and prepare for the future under scarcer resources will be an issue that both government and providers must address in the months ahead. Only one scenario is clear right now: The flush days of health care—and the time for playing cat and mouse with health care funding—are over. Now may actually be the time when we figure out how important health care is to people, and how we're going to pay for it.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

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